

Female orgasm disorders: A clinical approach

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ABSTRACT. *Female orgasmic disorders are a prevalent problem that can affect quality of life. This article provides a review of the biopsychosocial factors affecting female orgasm and a review of the assessment and treatment of female orgasmic disorders. Clinical assessment and treatment should be multidisciplinary, involving biomedical, psychosocial, and sexual aspects. Currently available therapies that have received clinical research attention include cognitive-behavioral therapy and pharmacotherapy. The importance of female orgasmic functioning as a quality of life issue warrants ongoing controlled biopsychosocial research.*

Urologica 14: 99-104, 2004

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INTRODUCTION

Female orgasmic disorders are a prevalent problem that can affect couple relationships and generate emotional distress (1, 2). It has been estimated that from 5% to 30% of women in community- and population-based studies and from 18% to 76% of women in clinic-based studies report difficulty in reaching orgasm or dissatisfaction with orgasm frequency (3-5). In one American study, orgasmic difficulties were the second most common sexual complaint reported by women (24%) (5).

BACKGROUND

Diagnosis

The Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM-IV-TR) (6) defines Female Orgasmic Disorder as the "persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase" that causes personal distress or interpersonal problems (i.e., the partner is distressed). A recent consensus-

development committee on defining sexual dysfunctions further recommended that the diagnosis be applied only when the presenting individual reports distress; distress reported by the partner, but not the presenting individual, does not merit the diagnosis (1). In addition, the majority of women are unable to attain orgasm through intercourse alone (e.g., 4, 7); clitoral stimulation appears essential to trigger orgasm, even during intercourse (7). Hence, the capacity to have masturbatory orgasm but not coital orgasm, even though it may cause personal distress, is viewed as a normal aspect of female sexual functioning (e.g., 8).

Etiological factors

A formal DSM diagnosis of Female Orgasmic Disorder includes categorizing the etiology of the disorder and ruling out organic factors (i.e., medical conditions, substance use, medications) and other Axis I psychopathologies (6). However, the Consensus Committee proposed that the etiological categories for sexual disorders should include organic factors (1); accordingly, Female Orgasmic Disorder can be attributed to organic, psychogenic, mixed, or unknown factors. Numerous biopsychosocial factors have been investigated for their impact on female orgasm functioning and orgasmic dysfunction. Table 1 summarizes some of these factors. A detailed review of these factors is beyond the scope of this article; interested readers are directed to the many comprehensive reviews available (e.g., 4, 7, 9). Because research concerning orgasmic disorders typically entails observational studies rather than controlled experiments, few of these factors can be considered definite or direct determinants of female orgasm functioning and orgasm disorders (4).

CLINICAL APPROACH

Assessment

In assessing the presenting problem, the DSM-IV-TR subcategories of female orgasmic

disorder (lifelong vs acquired; generalized vs situational) (6) provide one useful organizing structure. Maurice (8), for example, discussed the lifelong/generalized ("anorgasmia"), lifelong/situational, and acquired/generalized orgasmic disorders as the three most common clinical presentations of female orgasmic dysfunction. This structure reflects the core content and contextual issues to be assessed: a) duration (e.g., "Have you been able to have orgasms before?", "When did you first notice the problem?"); b) partner-related sexual activities (e.g., "Have you ever had orgasm during intercourse? With manual or oral stimulation from your partner?", "Do you or does your partner stimulate your clitoris during intercourse?"); c) masturbation activities (e.g., "Have you ever masturbated? With a vibrator?", "Have you ever had orgasm this way?"); d) level of arousal (e.g., "On a scale of 1-10, how sexually excited do you get during intercourse? During non-coital stimulation from your partner? During masturbation?"); e) qualitative changes (e.g., "Have you noticed changes in your orgasm experience?", "Has orgasm become noticeably less intense or less pleasurable? Do you have pain during orgasm?"); and f) reactions to and attitudes about the problem (e.g., "What do you think or feel when orgasm doesn't occur?", "What does your partner say when you don't have orgasm?") (8).

In accordance with the Consensus Committee's proposed etiological subtypes (organic, psychologic, mixed, unknown) (1), assessment of contributing factors should include both a physical examination, to identify or rule out organic factors, and a thorough review of medical, psychological, relationship, and sexual and psychosexual functioning. Reviewing multiple domains besides the biomedical is important given that female sexuality may be significantly influenced by psychosocial factors. Table 1 lists many of the biopsychosocial factors that should be assessed. More pertinent factors include the fol-

Table 1 - Factors reported to be associated with female orgasm.

Biological factors	Psychosocial factors
<i>peripheral nervous system</i> - hypogastric, pelvic, and pudendal nerves (+) - vagus nerve (?)	<i>sociodemographic characteristics (+)</i> - age - marital status (with partner) - educational status
<i>central nervous system (+)</i> - T10-L2 and S2-S5 spinal levels - various cortical and subcortical structures (e.g., prefrontal cortex, frontal-temporal cortex, septum, amygdala, cingulate, basal ganglia, hypothalamic structures)	<i>psychological adjustment factors (-)</i> - self-blame attributional style - repressed emotions - need for control - conservative attitudes - dependency - apprehensiveness, negativity - psychiatric conditions
<i>neurotransmitter systems</i> - cholinergic (?) - adrenergic, noradrenergic (+) - dopaminergic (+) - serotonergic (-)	<i>sexual behaviours (+)</i> - triggers of orgasm - clitoral and mons stimulation - vaginal, cervical, and G-spot stimulation - pubococcygeal muscle strength - breast stimulation - mental imagery, fantasy - initiation of sexual activity by woman - frequency of masturbation, intercourse, and overall sexual activity - use of sexual fantasy - varied sexual activity, extended foreplay, sexual experimentation - uninterrupted genital stimulation
<i>neuroendocrine systems</i> - steroid hormones (e.g., androgens [+], estrogens [?]) - oxytocin (+) - prolactin (-) - neuropeptides (e.g., vasoactive intestinal peptide, opioids) (?)	<i>psychosexual factors</i> - premarital sexual experiences (+) - sexual responsiveness (+) - attitudes about masturbation (+) - awareness of physiological arousal (+) - sexual compatibility with partner (+) - partner involvement in sexual activity (+) - sexual abuse history (-) - sex guilt (-) - low sexual desire or arousal (-)
<i>psychotropic medications (-)</i> - antidepressants (e.g., SSRIs, tricyclics, MAOIs) - benzodiazepines - neuroleptics (especially prolactin-elevating drugs)	<i>interpersonal factors (+)</i> - marital stability, happiness, and satisfaction - emotional closeness to partner - early relationship quality with parental figures
<i>other medications</i> - antihypertensive medications (-) - anti-epileptic drugs (-) - drug treatments for orgasm disorders (e.g., amantadine, bupropion, cyproheptadine, ephedrine, ginkgo-biloba, mirtazapine, olanzapine, vasoactive drugs [e.g., sildenafil], yohimbine) (?)	<i>cultural factors (-)</i> - sociocultural control of sexual expression
<i>substance use</i> - moderate alcohol intake (+) - heavy alcohol use (-) - substance use (e.g., cocaine, amphetamines) (-)	
<i>medical conditions with neurological, vascular, or other physiological involvement</i> - multiple sclerosis (-) - diabetes (?) - spinal injury (-) - neuroanatomical damage from surgical procedures (e.g., pelvic surgeries) (-)	

These factors are listed without considering either the methodological quality of the studies in which they were investigated or whether the reported relationship is direct vs indirect. The following symbols denote the direction of the relationship reported in studies between a factor(s) and higher female orgasm frequency, strength, or satisfaction or improvements in orgasmic disorders: (+) = positive relationship, (-) = negative relationship, (?) = relationship unclear.

lowing: knowledge about orgasmic and sexual functioning, sexual repertoire, functioning across the sexual response cycle, and comorbid sexual dysfunctions such as lack of sexual desire, sexual arousal, or premature ejaculation in the partner; quality of the couple relationship; historical review of relationships and sexual functioning, including sexual abuse or trauma; recent stressors; comorbid psychopathologies; medical conditions and medications; and alcohol and substance use.

Empirically investigated treatment strategies

Cognitive-behavioral therapy (CBT). The goals of this multi-faceted therapy include a) promoting changes in sexual knowledge, beliefs, and attitudes, b) decreasing anxiety about sex, c) expanding the sexual repertoire, and d) increasing connections between positive feelings and sexual behaviors (4, 10). Behavioral exercises form a core component of CBT. Depending on assessment findings, sex education, communication-skills training and couple therapy, self-help components (bibliotherapy), and other exercises to promote cognitive and interpersonal changes are typical adjuncts (10). With conflictual relationship issues, for example, couple therapy to improve communication and negotiate conflicts may be helpful for some, in addition to sex therapy (11, 12). For couples concerned about being unable to attain coital orgasm, normalizing strategies involving sex education and referral to published sources, indicating that the majority of women cannot attain coital orgasm without additional clitoral stimulation, should be employed (e.g., 8).

Directed masturbation (DM) is the most frequently prescribed treatment for lifelong/generalized orgasmic difficulties (4, 10). DM typically begins with sex education. Individuals then engage in private visual exploration of their body, including the genitals, to attain familiarity and comfort with the body and genitals. Finally, individuals stimulate their genitals to discover the stimulation needed to

trigger orgasm. Controlled studies have shown that DM is effective: success rates for achieving masturbatory orgasm with DM range from 47% to 100% for lifelong anorgasmia and from 10% to 75% for acquired anorgasmia (4, 10).

Orgasmic consistency training (OCT) involves a structured sequence of exercises (13) to address lifelong/situational difficulties (e.g., orgasm achieved through masturbation but not coitus). First, the couple engages in sensate focus, a sequence of body-touching exercises that begins in a non-sexual manner and then progresses in an increasingly sexual manner. This includes non-demand genital touching by the partner, followed by manual and then penile stimulation of the woman's genitals, and finally intercourse. Sensate focus helps couples shift away from goal-focused orgasm and more towards awareness of sexually sensitive bodily areas, pleasurable sensations, and freer sexual communication (4). The couple then learns the coital alignment technique (CAT), a variant of the missionary position (2, 13). The man rests on top of the woman but farther forward, and then both partners move their pelvis in a rocking motion. The resulting penile-clitoral contact theoretically provides clitoral stimulation to trigger orgasm. Studies of OCT have shown that women who completed DM training and were assessed prior to CAT training were more likely to report achieving orgasm during intercourse than those who completed both DM and CAT training and were assessed after CAT training (13). This difference may be attributable to the fact that DM advocates additional clitoral stimulation during intercourse, whereas CAT does not (13). However, these findings require replication (cf. 2).

Some have argued that these procedures work by reducing sexual-performance anxiety (e.g., 4, 10). For example, sensate focus might be a form of systematic desensitization: It involves a hierarchy of touching exercises that removes the imperative of achieving or-

gasm and reduces self-monitoring ("spectatoring") and performance anxiety (e.g., 4). The effectiveness of other anxiety-reduction techniques like relaxation training can be difficult to evaluate because such techniques are typically part of a multi-component treatment plan. Anxiety-reduction techniques alone, however, have not shown great promise for orgasmic difficulties when evaluated in controlled studies (4, 10).

Pharmacological therapy. Pharmacological treatments attempt to facilitate the neurophysiological mechanisms underlying orgasm or to counteract the sexual side effects of medications. Of recent interest in the treatment of female sexual dysfunctions has been the drug sildenafil. Its vasoactive properties may help increase physiological arousal and in turn the likelihood of achieving orgasm. However, this mechanism of action, as well as the efficacy of sildenafil in treating female sexual dysfunctions in general, still needs to be evaluated with placebo-controlled studies (10). Many psychotropic medications and other pharmacological agents have sexual side effects, including inhibition of orgasm (Table 1). On the whole, findings from controlled studies of pharmacological agents are mixed or suggest little benefit beyond placebo in treating both medication-induced female orgasmic dysfunction and female orgasmic dysfunction in general (e.g., 10).

CONCLUSIONS

Because female orgasm is widely viewed as essential to sexual satisfaction, female orgasmic disorders should be addressed within the context of individual quality of life and couple satisfaction. The complex factors underlying female orgasmic disorders suggest a multidisciplinary approach to assessment and treatment. Considering the impact of psychosocial factors on female orgasm, this should include expertise in sex and couple therapy.

Clinical practice would further benefit from continued investigation of the subjective characteristics and physiological mechanisms of female orgasm and how they interact to produce the orgasm "experience". Female orgasm, especially its physiological aspects, is less well understood than male orgasm (e.g., 7, 10). To advance knowledge about its primary characteristics and functional mechanisms, controlled studies should incorporate both physiological and subjective measures. While measures of genitopelvic (e.g., vaginal blood volume, vaginal and anal muscle contractions) and extragenital changes (e.g., heart rate, blood pressure) during orgasm exist, imaging technology (e.g., fMRI) may provide more precise data on such changes. There is also a need for a standardized self-report measure of the psychological experience of female orgasm. We are engaged in the ongoing evaluation of an adjective checklist, the Orgasm Questionnaire, to assess the components of the subjective orgasm experience (7). Finally, other research directions include placebo-controlled trials of substances reported in case or uncontrolled studies to alleviate female orgasmic disorders (10), and controlled studies comparing the relative treatment efficacy of individual components of multi-faceted treatment programs like cognitive-behavioral therapy. Findings from such efforts would help advance the effective treatment of female orgasmic disorders.

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